~~Preliminary Draft: For D~~iscussionRevised Draft: For Discussion and Adoption
(Contents and recommendations herein have not been approved by the Task Force)

STANDARDIZING HEALTH INSURANCE CONTRACTS
~~EXECUTIVE SUM~~MARYFINDINGS AND RECOMMENDATIONS

I. HEALTH INSURANCE CONTRACTS

Health insurance contracts are ~~inherent~~lyextremely complex and difficult to interpret, even by experts. This is inherent in the nature of the subject and not necessarily the result of any deliberate action on the part of health plans (i.e., health insurance arrangements or health benefits financial intermediaries) or the employers whose coverage ~~interpre~~t.contract decisions may add to the complexity. The complexity of coverage contracts makes it very difficult for an individual or small group to be a competent purchaser of health insurance.

Complexity offers insurers opportunities to exercise~~cost-increa~~sing strategies that promote their economic advantage. While all health plans may not employ these strategies or may not employ them intentionally but rather to accommodate consumer or employer demand, these strategies can put upward pressure on the price of health care ~~are beneficial to the insurers, but not to consu~~mers, including:coverage. Strategies include: (1) product differentiation that makes comparisons difficult,~~reduces pr~~ice-~~elasticity of demand~~ which decreases the incentive for health plans to offer lower prices, and raises switching costs by making it more ~~expensive~~"expensive", in terms of time for example, for a consumer to switch plans to save money; (2) market segmentation that ~~limits~~may reduce competition by dividing customers into ~~groups by pro~~duct ~~desig~~n;distinct groups, with each insurer marketing products to attract different segments from those chosen by competitors; (3) risk selection by designing products that are unattractive to high risk persons; and (4) coverage exclusions, ~~hidden in the~~ fine ~~print~~.not readily apparent in coverage contracts.

II. STANDARDIZATION TO SIMPLIFY, ~~PROTECT~~,COMPARE, AND REDUCE COSTS

To ~~protect~~assist consumers, major purchasers have standardized coverage contracts. In order to offer both HMOs and PPOs, contracts must vary with respect to cost-sharing. However, a standardization policy can seek to make contracts as similar as possible. Doing so will increase understanding, reduce administrative costs, and facilitate comparisons.

Implementation of standardization has proved difficult at the level of detail. Issues regarding definitions and exclusions will continue to challenge attempts to standardize until greater clinical agreement exists. Despite its challenges, standardization has worked successfully for major purchasers in California. However, while large employers and employer coalitions have the resources to ~~protect~~assist their members adequately without assistance from regulators, small groups and individuals need help.

Recently, Congress passed a law that only approved reference packages could be sold in the Medi-Gap market for supplemental Medicare insurance. Indications so far are that this market is now working much better for consumers.

Standardization need only apply within sponsored groups, i.e., the set of people choosing among a set of plans; it does not need to apply among them, i.e., across employers purchasing separately. The principle of standardization does not imply that small business must have the same package as large employers. Standardization need not and should not be complete or mandatory as this would reduce choice and stifle innovation.

A. Concerns Regarding Standardization

Standardization has been criticized as denying people choice of product features. Certainly, there is need for choice; consumers want it, and it provides a source of constant innovation. Options and innovation often benefit consumers, and standardization should not preclude them. However, ~~due to~~because of the potential for risk selection (e.g., only~~AIDS~~ patients who need it will want coverage for ~~AIDS drugs), this argument is not~~ valid.durable medical equipment), some standardization is desirable. Whole groups must make a decision as to whether or not they want a particular type of coverage, and if~~it does, it must~~they do, they need to apply this standard uniformly to all plans serving their members.

~~Standardization need only apply within sponsored group~~s, not among them. ~~Furthermore, con~~trolledControlled departures from complete standardization are possible and desirable, for example, but must be balanced against the benefits of standardization, with special care not to select risks and segment markets.

B. Standardization Options

There is a continuum of pro-standardization policies that the ~~State~~state could adopt. From the most prescriptive to the least, they include, but are not limited to:

- A uniform, national contract, as is the case of Medicare.
- A "Medi-Gap" solution. This would involve a set of standard coverage options and a requirement that, at least in certain markets (e.g., small group market), insurers offer only those products.
- A set of "endorsed reference packages", ~~probably with approved variation~~s such as ~~more or less cost-sharing, designed with the participation~~ of small employer ~~associations and the~~ HIPC,designed and updated periodically in consultation with the Major Risk Medical Insurance Board, small business associations, small group purchasing organizations, consumer organizations, health plans, and providers, and reviewed and approved by the ~~Department of Corp~~orations~~. Health plans w~~ould be ~~able to offer the endorsed referenc~~e packagesstate's health plan regulatory ~~witho~~ut ~~further review, rather than seeking approval fo~~r each product.agency or agencies. Health plans could be required upon request of employers and consumers, to provide a clear and concise comparison between any plan they offer in the small group or individual market and one of the reference contracts.

III. TASK FORCE FINDINGS AND RECOMMENDATIONS

Non-standard coverage contracts add to ~~transactions~~ cost~~s,~~financial and other costs associated with switching plans, help to segment markets, and ~~make demand price-inelastic~~decrease the incentive for health plans to offer lower prices thus raising prices to

purchasers and consumers. Market efficiency can be enhanced by standardization within large groups and by making endorsed standard reference contracts available for ~~use~~comparison in the small group and individual market.

1. The Governor should direct the ~~Department of Corporations to ado~~pt a positive ~~stance~~In ~~addition, the DOC should work with the HIPC, small b~~usiness associations, state's health plan regulatory agency or agencies to adopt a pro-active policy toward the development of standard reference coverage contracts that can be used by buyers and sellers by reference, that health plans can offer without new approvals in each case.

2. ~~and other small group purchasing o~~rganizations(a) The Governor and the Legislature should direct the state's health plan regulatory agency or agencies to develop a set of ~~10 or more~~five (5) standard reference ~~packages or con~~tracts,coverage contracts in each of the HMO, POS, PPO, and indemnity product lines, from minimal to comprehensive, that can be used by buyers and sellers in the small group and individual markets along with explanatory materials to help buyers understand their choices.

   (b) This should be done in consultation with the Major Risk Medical Insurance Board, small business associations, small group purchasing organizations, consumer organizations, health plans, and providers.

   (c) On a biennial basis, the state's health plan regulatory agency or agencies should re-examine standard contracts and adopt modifications as appropriate.

   (d) Small business would not be required to limit its choices to these standard packages ~~and even could take the initiative to develop new on~~es. But, in effect, ~~Department of Corporations approval for the standard~~ packages would be ~~"fast tracked", and the market~~ could but in addition would be able to select any other contract health plans offered. But, in effect, approval by the state's health plan regulatory agency or agencies for the standard contracts would be "fast tracked". ~~be expected to evolve increasingly around the standard~~ reference packages.

   (e) Health plans should be required to publish or provide upon request of employers and consumers, to provide a clear and concise comparison between any plan they offer in the small group or individual market and one of the reference contracts.

3. (a) The Governor and the Legislature should direct the state's health plan regulatory agency or agencies to convene a working group to develop a standard outline and definitions of terminology for Evidence of Coverage (EOC) and other documents to facilitate consumer comparison and understanding.

(b) The working group should include the major stakeholders such as employers, health plans, purchasing organizations, providers, and consumer organizations. The working group should build on previous accomplishments by organizations such as

CalPERS, PBGH, and the HIPC. The regulatory agency should convene the working group on a biennial basis to consider modifications.

(c) When consensus has been achieved, the regulatory agency should adopt the working group's proposal by regulation.

STANDARDIZING HEALTH INSURANCE CONTRACTS
BACKGROUND PAPER

I. HEALTH INSURANCE CONTRACTS

A health insurance contract consists of a list of covered services (i.e., services that will be paid for in whole or in part by the insurer) such as preventive services, physician services, etc. Covered services are subject to a schedule of deductibles, coinsurance and copayments, to limitations such as 30 days per year for inpatient mental health, to exclusions such as of medically unnecessary services, experimental or investigational therapies, and certain procedures. In managed care, covered services must be obtained from contracting providers, medical necessity is determined by the judgment of the participating physicians or the plan's medical director, and in many cases must be approved in advance of treatment, and, in response to the demands of payors for cost containment, exclusions of unnecessary and investigational services are enforced.

A. Inherent Complexity

Health insurance contracts are extremely complex and difficult to interpret, even by experts. This is inherent in the nature of the subject and not necessarily the result of any deliberate action on the part of health plans (i.e., health insurance arrangements or health benefits financial intermediaries) or the employers whose coverage ~~insurer~~s.contract decisions may add to the complexity. Employers' decisions are often influenced by the particular features of their employee relations. Evidence of Coverage documents are so over-burdened by regulatory disclosure requirements that finding relevant information can be a difficult task.

Even "simplified" presentations of health insurance contracts are not easy to understand. For example, the simple summary of California Public Employees Retirement System (CalPERS) covered benefits takes 45 lines to describe one plan. Previously, when each CalPERS health plan contract was different, understanding the alternatives would require mastery of about 1000 items. Much of the important distinctions occur in the fine print which is even more complex. Furthermore, people typically do not read their health insurance contracts until they need care, and they often can not appreciate the subtle differences in the meaning of important terms until they have experienced a problem.

~~There is no clear, agreed-upon def~~inition of "~~medical nece~~ssity~~", and the frequen~~cy of ~~many medical procedures per capita varies five-fold among d~~ifferent communities ~~suggesting a wide range of different opinions as to what is m~~edically appropriate.[1] ~~The~~re ~~is also no agreed or clear standard~~ for what is "~~experimen~~tal"~~. In a nation popul~~ated by ~~creative, innovative, entrepreneurial doctors who invent new tre~~atments and advocate ~~them persuasively, there is much room for disagreem~~ent as to what is a "~~prove~~n" ~~technology, and standards of proof ar~~e evolving.The complexity of health insurance contracts is compounded by the great variety of products health plans offer in response to consumer demand. Having a wide variety of products allows, for example, smaller

[1] ~~John Wennberg, *The Dartmouth Atlas of Health Care*, Chicago: American Hospital Association, 1996.~~

employers to select more basic packages that do not cost as much, while larger employers can offer high-option plans. Individuals who can barely afford coverage may prefer plans with high deductibles and coinsurance so that monthly premiums are low, but the person has coverage for major illnesses. Different consumers have different needs and different abilities to pay. Variety accommodates these differences.

The complexity of coverage contracts makes it very difficult for an individual or small group to be a competent purchaser of health insurance. Rather, the most promising method for achieving a satisfactory contract involves a large group that purchases a specified coverage contract, armed with the professional advice it can afford, and that negotiates revisions based on the aggregate experience of the group as unsatisfactory provisions appear.

B. Insurance Strategies Based on Complexity

Complexity also offers insurers opportunities to exercise strategies that promote their economic ~~advantage at the expense of consume~~rs. Some ofadvantage. While all health plans may not employ these strategies ~~have been major contributors to th~~e explosive ~~increase~~ inor may not employ them intentionally but rather to accommodate consumer or employer demand, these strategies can put upward pressure on the price of health care coverage.

First, insurers can differentiate their product from others by offering a combination of features unlike those offered by any other carriers. This makes it very difficult for the customer to understand the differences and to make “apples versus apples” comparisons. This strategy shifts attention from price to features. By decreasing the ability of individuals to compare plans, product differentiation decreases the “price-elasticity of demand” which decreases the incentive for health plans to offer lower prices. Product differentiation raises “switching costs” by making it more “expensive” for a consumer to switch from one plan to another in the hope of saving money. Who can afford to devote the days of his life needed to understand the differences among policies in the hope a smart choice might save $200 per year. Some people rely on experts (agents, brokers and consultants) for advice, but these experts may have their own economic interests and biases.

Second, insurers can segment markets by ~~offering~~marketing product designs ~~that c~~an ~~divide customers into separate groups according to the produc~~t design they choose, ~~limiting~~to targeted segments of customers that are different from the segments competitors market to, reducing competition for the same customers. An example of this occurred at Stanford University in the 1970s. Employees were offered a choice of ~~Kaiser Permanente~~two plans: one, that~~,~~ as part of its benefit package, covered all the costs of medical services for pregnancy and delivery, and the second, a prepaid plan that allowed employees to seek care at the local clinic, but did not cover pregnancy and delivery~~and a Palo Alto Medical Clinic (PAMC) prepaid plan that~~ did not cover such costs. The result, as could have been expected, was that those who were planning or expecting babies more often chose ~~Kaiser~~,the first plan, while those who were not, more

often chose ~~PAMC.~~the second. In this instance, the two health plans were not in head-to-head competition for the same customers.

Market segmentation is a time-honored business strategy for raising profit margins and reducing competition in any industry. Market segmentation is particularly important in the case of managed care plans because the typical community will only be able to support several managed care plans and because there are many variables that can be used to segment markets. Health plans' ability to segment markets has been limited in the 2-50 group market by small group reform.[2] In addition, in order to be federally qualified, HMOs must community rate,[3] which by definition precludes segmentation by risk pools.

Third, insurers can design coverage contracts to select risks. ~~There are lit~~erally ~~endless~~Despite laws that place many restrictions on Knox-Keene regulated health plans,[4] there are many ways in which HMO and other health insurance contracts can be designed to make them unattractive to people with above average health risks, including~~higher deductibles~~ and coinsurance, limits on benefits~~,~~ and exclusions from coverage (refer also to Task Force paper on Risk ~~Adjustment: A Cure for~~ Adverse ~~Selection~~).Avoidance).

Fourth, insurers can cut costs by including ~~in coverage contracts tricky e~~xclusions, ~~hidden in obscure language in the fine print. In the early 1~~990s when CalPERS ~~embarked on an effort to standardize its coverage contracts, the~~y discovered that one ~~plan that covered organ transplants in the bold print exclu~~ded coverage of the exclusions in coverage contracts. Given the length and complexity of the typical Evidence of coverage, augmented by the many mandatory disclosure requirements, these exclusions may not be readily apparent.
~~expenses of harvesting and transporting the organ in the fine print~~, obviously making the ~~transplant itself impossible. Until then, this provisions had esca~~ped the expert staff at ~~CalPER~~S.

II. STANDARDIZATION TO SIMPLIFY, ~~PROTECT,~~COMPARE, AND REDUCE COSTS

Purchasers and consumer advocates must ~~protect consumers in the fac~~e of these ~~potent~~ial ~~strategie~~s.help consumers overcome the complexity. For the sake of equity and simplicity, purchasers should provide program participants with the same financial protection regardless of the plan they choose. To do so, major purchasers such as CalPERS, the University of California, Stanford, Pacific Business Group on Health (PBGH), the Health Insurance Plan of California (HIPC), and others have adopted the

[2] AB 1672 1993.
[3] Federal qualification requires strict community rating, community rating by class, or community rating within 10% of the other methods.
[4] Knox-Keene health plans must cover all basic health care services and may charge only nominal copayments, may not exclude any type of disease or treatment, must cover everything medically necessary as defined by the community standard of care, and may not exclude an individual that is part of a group nor fail to renew a group for health reasons.

policy of standardizing the coverage~~s~~ they buy. Typically, they buy one standard contract for all health maintenance organizations (HMOs). Preferred provider organizations (PPOs), which pay providers a fee for service, must rely heavily on consumer cost-sharing since they do not have the ability of HMOs to control costs by putting providers at risk. Therefore, PPO contracts need to differ from HMO contracts with respect to cost-sharing, as is the case, for example, with CalPERS. Still, a standardization policy can seek to make contracts as similar as possible and different only where required. By standardizing the contract, management can have a much better chance of understanding what it is buying, administrative costs can be lower because staff in the benefits office need to learn only one contract, and participants can easily make comparisons among plans.

Given acceptance of the goal of standardization, one should not think that this policy is easily achieved. Implementation of standardization has proved difficult at the level of ~~the fine p~~rint.detail. Issues regarding definitions and exclusions will continue to challenge attempts to standardize until greater clinical agreement exists, as will limitations in our ability to detect and reduce practice variations across plans. Several California purchasers, including CalPERS and PBGH, have attempted or are attempting to reduce variation among coverage contracts at this level.

Despite its challenges, standardization has worked~~extreme~~ly successfully for major purchasers in California. It has~~created~~ greatly increased ~~price-elasticity of d~~emandthe incentive for health plans to offer low prices which is the most powerful antidote to excess health plan profit margins; it has simplified administration; and it has enhanced the bargaining power of purchasers such as CalPERS that must rely on bargaining. These purchasers would all affirm that standardization was ~~an essentia~~la valuable ingredient in bringing prices down.[5] However, while large employers and employer coalitions have the resources to ~~protect~~assist their members adequately without assistance from regulators, small groups and individuals need help.

An important recent case of standardization was action taken by Congress in the market for supplemental insurance for Medicare, called the "Medi-Gap" market. In the previously non-standardized market, consumers were confused, often bought wasteful, overlapping coverage, and were not able to make economical choices.[6] In response, Congress asked the National Association of Insurance Commissioners (NAIC) to design a set of standard supplemental coverage contracts, from the barest to the most comprehensive, with the clear understanding that purchase of a more comprehensive coverage would obviate the need for a less comprehensive coverage. Then Congress passed a law that, starting in 1992, the only contracts allowed to be sold in the Medi-Gap

[5] See for example, Buchmueller TC and Feldstein PJ, "Consumers' Sensitivity to Health Plan Premiums: Evidence from a Natural Experiment in California", *Health Affairs*, 15:1, Spring 1996, 143-151.

[6] Select Committee on Aging, US House of Representatives, "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal", Committee Pub. no. 95-160, Washington, DC: US Government Printing Office, 1978.

market were those standard contracts. Indications so far are that this market is now working much better for consumers.[7]

Standardization need only apply within sponsored groups, i.e., the set of people choosing among a set of plans; it does not need to apply among them, i.e., across employers purchasing separately. The principle of standardization does not imply that small business must have the same package as large employers. Standardization need not and should not be complete or mandatory as this would reduce choice and stifle innovation.

A. Concerns Regarding Standardization

Standardization has been criticized as an example of "one size fits all thinking" and as denying people the choice of features they need and want. Certainly, there is need for choice; consumers want it, and it provides a source of constant innovation. Options and innovation often benefit consumers, and standardization should not ~~To understand~~ why ~~this argument is not valid, one must u~~nderstand the preclude them. However, special features of the health insurance ~~marke~~t. market make some standardization desirable. Risk selection is ~~always a major factor. I~~f peoplean unfortunate fact of the health insurance market (See Task Force paper on Risk Avoidance). If individuals want to buy a particular coverage feature, it is almost surely because they consider themselves to be more likely to use it.

Suppose some insureds say "I neither need nor want coverage of ~~AIDS dr~~ugs~~":~~durable medical equipment (DME). If Plan A decides to exclude coverage of ~~AIDS dr~~ugs,DME, it can be sure that it will not be chosen by ~~AIDS patients,~~ whopatients who need it. They will look elsewhere for coverage. This will put the other plans at a competitive disadvantage, which will force them to emulate Plan A or risk being driven from the marketplace. Under these circumstances,~~AID~~S patients who need DME suffer. Whole groups must make a decision as to whether or not they want coverage of ~~AIDS dr~~ugs, ~~and if it does, it~~ mustDME, and if they do, they need to apply this standard uniformly to all plans serving their members.

~~Standardization need only apply within sponsored groups, ~~i.e., the set of people ~~choosing among a set of plans; it does not need to ~~apply among them~~, i.e., acr~~oss ~~employers purchasing separately. The principle of standardizat~~ion does not imply that ~~small business must have the same package as large empl~~oyers. Furthermore, ~~controll~~edControlled departures from complete standardization are possible and desirable, for example with respect to cost-sharing, but must be balanced against the benefits of standardization, with special care not to select risks and segment markets.

B. Standardization Options

There is a continuum of pro-standardization policies that the State could adopt. From the most prescriptive to the least, they include:

[7] Thomas Rice, et al., "The Impact of Policy Standardization on the Medigap Market", *Inquiry*, 34:2, Summer 1997, 106:116.

- A uniform, national contract, as is the case of Medicare. Given the current political climate and the need for continued innovation and different benefit packages to satisfy different consumers, there is no~~apparent~~ support for this proposal at this time.
- ~~A~~ A "Medi-Gap" solution. This would involve a set of standard coverage options and a requirement that, at least in certain markets (e.g., small group market), insurers offer only those ~~product~~s.
- products. There is little support politically for this option either, since the benefits of standardization can be achieved by standardization within groups without requiring standardization across groups.
- A set of "endorsed reference packages", ~~probably with approved variation~~s such as ~~more or less cost-sharing, designed with the participation~~ of small employer ~~associations and the~~ HIPC,designed and updated periodically in consultation with the Major Risk Medical Insurance Board, small business associations, small group purchasing organizations, consumer organizations, health plans, and providers, and reviewed and approved by the ~~Department of Corporations. Health p~~lans would be ~~able to offer the endorsed referenc~~e packagesstate's health plan regulatory ~~witho~~ut ~~further review, rather than seeking approval for each produc~~t. Purchasers would ~~have some standard reference points and could ask carriers or~~ brokers for quotes for ~~the reference package of their choice. Consume~~rs could become ~~familiar w~~ith ~~reference packages and could have confidence in their cove~~rage. Insurers might ~~achieve greater legitimacy for their product offerings by usin~~g endorsed reference ~~package~~s.agency or agencies. Health plans could be required upon request of employers and consumers, to provide a clear and concise comparison between any plan they offer in the small group or individual market and one of the reference contracts.

III. TASK FORCE FINDINGS AND RECOMMENDATIONS

Non-standard coverage contracts add to ~~transactions c~~osts,financial and other costs associated with switching plans, help to segment markets, and ~~make demand p~~rice-~~inelastic~~decrease the incentive for health plans to offer lower prices thus raising prices to purchasers and consumers. Market efficiency can be enhanced by standardization within large groups and by making endorsed standard reference contracts available for ~~use~~comparison in the small group and individual market.

1. The Governor should direct the ~~Department of Corporations to~~ adopt a po~~sitive stance~~state's health plan regulatory agency or agencies to adopt a pro-active policy toward the development of standard reference coverage contracts that can be used by buyers and sellers by reference, that health plans can offer without new approvals in each ~~case. Thus, for example, one or a few standard PB~~GH HMO benefit case. ~~packages could be approved for use by all carriers serving PB~~GH members without ~~further review and ap~~proval.

   ~~In addition, the Department of Corporations should~~ work with the H~~IPC, sm~~all ~~business associa~~tions,
2. ~~and other small group purchasing o~~rganizations(a) The Governor and the Legislature should direct the state's health plan regulatory agency or agencies to develop a set of ~~10 or mor~~efive (5) standard reference ~~packages or con~~tracts,coverage contracts in

each of the HMO, POS, PPO, and indemnity product lines, from minimal to comprehensive, that can be used by buyers and sellers in the small group and individual markets along with explanatory materials to help buyers understand their choices.

(b) This should be done in consultation with the Major Risk Medical Insurance Board, small business associations, small group purchasing organizations, consumer organizations, health plans, and providers.

(c) On a biennial basis, the state's health plan regulatory agency or agencies should re-examine standard contracts and adopt modifications as appropriate.

(d) Small business would not be required to limit its choices to these standard packages ~~and even could take the i~~initiative ~~to develop new ones. But,~~ in effect, ~~DOC approval for the standard packa~~ges would be ~~"fast tracked", and the ma~~rket ~~could be~~ but in addition would be able to select any other contract health plans offered. But, in effect, approval by the state's health plan regulatory agency or agencies for the standard contracts would be "fast tracked".
~~expected to evolve increasingly around the standard r~~eference packages.
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(e) Health plans should be required to publish or provide upon request of employers and consumers, to provide a clear and concise comparison between any plan they offer in the small group or individual market and one of the reference contracts.

3. (a) The Governor and the Legislature should direct the state's health plan regulatory agency or agencies to convene a working group to develop a standard outline and definitions of terminology for Evidence of Coverage (EOC) and other documents to facilitate consumer comparison and understanding.

(b) The working group should include the major stakeholders such as employers, health plans, purchasing organizations, providers, and consumer organizations. The working group should build on previous accomplishments by organizations such as CalPERS, PBGH, and the HIPC. The regulatory agency should convene the working group on a biennial basis to consider modifications.

(c) When consensus has been achieved, the regulatory agency should adopt the working group's proposal by regulation.